

**UNITED STATES DISTRICT COURT  
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION**

**ROSIE D., *et al.*,**

**Plaintiffs,**

**v.**

**DEVAL PATRICK, *et al.*,**

**Defendants.**

**CIVIL ACTION  
NO. 01-30199-MAP**

**REPORT ON IMPLEMENTATION**

The Defendants hereby submit this Report on Implementation (“Report”) pursuant to paragraphs 37(c)(i), 38(d)(i), 39(c)(i), and 47(b) of the Judgment dated July 16, 2007 in the above-captioned case (“Judgment”).

This Report details the steps that the Defendants currently have taken to implement the tasks in Projects One through Four in the Judgment. For this purpose, the Defendants construe Projects One through Four to include all tasks described in paragraphs 2 through 46 of the Judgment.

Pursuant to the Judgment, the Defendants have until December 31, 2007 to complete Project One; until November 30, 2008 to complete Project Two; until June 30, 2009 to complete Project Three; and until November 30, 2008 to complete Project Four.

Taking paragraphs 2 through 46 of the Judgment in turn, the Defendants hereby report as follows:

***Paragraph 2: As set forth below, the Defendants will improve their methods for notifying Medicaid-eligible individuals enrolled in MassHealth (“MassHealth Members” or “Members”), MassHealth providers, public and private child-serving agencies, and other interested parties about the availability of behavioral health services, including the services described in Section I.D. below, and behavioral health screenings in primary care settings.***

This paragraph is introductory; see detailed response below.

***Paragraph 3: The Defendants will inform all EPSDT-eligible MassHealth Members (Members under age 21 enrolled in MassHealth Standard or CommonHealth) and their families about the availability of EPSDT services (including services focused on the needs of children with SED) and the enhanced availability of screening services and Intensive Care Coordination as soon as the EPSDT-eligible child is enrolled in MassHealth.***

The Defendants have updated the three notices that MassHealth sends to MassHealth members under the age of 21 to notify them about preventive health-care services, including EPSDT services. These notices are sent to members (1) when they are first enrolled in MassHealth; (2) when members are reenrolled in MassHealth after any break in MassHealth coverage; and (3) annually, on or around the member’s birthday.

These notices were first revised in June 2007 to specifically inform members that behavioral health screens are included as part of routine well-child care visits. These notices were further revised to include additional information about the standardized behavioral health screening tools. This further revised version went into distribution in February 2008.

The Defendants plan to revise these notices again (i) to provide more detailed information about the standardized assessment process using the Child and Adolescent Strengths and Needs (CANS) tool, in advance of its implementation; and (ii) to describe the remedy services, including how to access those services, in advance of their implementation.

***Paragraph 4: The Defendants will take steps to publicize the program improvements they are required to take under the terms of this Judgment to eligible MassHealth Members (including newly-eligible MassHealth Members), MassHealth providers, and the general public. As part of this effort, the Defendants will take the actions described below and will also provide intensive training to MassHealth customer service representatives, including updating scripts used by such representatives to facilitate timely and accurate responses to inquiries about the program improvements described in this Judgment.***

The Defendants executed a contract amendment with MassHealth’s customer services contractor in December, 2007. Pursuant to the terms of this amendment, the customer services contractor:

- Conducted an initial training for all Customer Service Representatives (CSRs) about EPSDT services, including information about the standardized behavioral health screens. These trainings took place during November and December, 2007, and were completed by December 31, 2007.

- Conducted a refresher training for all CSRs about new activities related to the behavioral health screens, which included information on the resources available to members and providers on EOHHS' Children's Behavioral Health Initiative page on the EOHHS website, and the availability of resources for primary care providers needing assistance with implementing the behavioral health screening requirement in their practices. These refresher trainings took place between April 16 and 25, 2008.
- Will continue to train new CSRs as they are hired and provide ongoing trainings for veteran CSRs about (i) EPSDT services, including information about the standardized behavioral health screens; (ii) the CANS tool once the tool has been implemented; and (iii) the remedy services, including how to access those services, once those services are implemented. The Defendants must review and approve the training curriculum used by the contractor.
- Updated its Knowledge Center, which is the library of materials accessed by CSRs, to include information about EPSDT services, including information about the standardized behavioral health screens.
- Will continue to update its Knowledge Center to include information about (i) EPSDT services, including information about the standardized behavioral health screens; (ii) the CANS tool, once the tool has been implemented; and (iii) the remedy services, including how to access those services, once they are implemented.
- Revised the voice menu that directs members and providers with questions about services for children to CSRs trained to answer questions about EPSDT.

Pursuant to contract requirements, MassHealth's behavioral health services contractor, the Massachusetts Behavioral Health Partnership (MBHP), and MassHealth's contracted Managed Care Organizations (MCOs), have completed intensive training for their CSRs about when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services, and have established a schedule for refresher trainings on updates to the behavioral health screens. Both MBHP and the contracted MCOs will ensure that all new CSRs will be trained about (i) when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services and (ii) the CANS tool, once the tool has been implemented; and (iii) the remedy services, including how to access those services, once they are implemented. Both MBHP and the MCOs will ensure that veteran CSRs will be trained on an ongoing basis about (i) when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services, including information about the behavioral health screens; (ii) the CANS tool, once the tool has been implemented; and (iii) the remedy services, including how to access those services, once they are implemented. The Defendants will review and approve the training curricula used by the contractors.

Further steps that EOHHS will take to publicize the program improvements to eligible MassHealth members, providers, and the general public are described in the paragraphs below.

***Paragraph 5: MassHealth Members - The Defendants will take the following actions to educate MassHealth Members about the program improvements they are required to take under the terms of this Judgment:***

- a. Updating and distributing EPSDT notices to specifically refer to the availability of behavioral health screening and services and to describe other program improvements set forth in this Judgment.***

See the response to paragraph 3 above.

Also, in December 2007, the Defendants mailed a new member notice to every household that included a MassHealth member under the age of 21 to inform these members about the program improvements described in the Judgment. This member notice also is being included in each distributed copy of the PCC Plan's member handbook, each MCO's member handbook, and MBHP's member handbook.

Prior to implementation of the remedy services, the Defendants will mail an updated member notice to every household that includes a MassHealth member under the age of 21 to inform these members about the program improvements described in the Judgment, including the CANS assessment process and the remedy services and how to access them. This member notice also will be included in each distributed copy of the PCC Plan's member handbook, each MCO's member handbook, and MBHP's member handbook.

- b. Updating and distributing (in the normal course of communications with MassHealth Members) Member education materials, including Member handbooks created by MassHealth and MassHealth's contracted managed care entities, to include description of these improvements, and how to access behavioral health screenings and services including the home-based services described in Section I.D.***

The Defendants are in the process of updating and distributing the following (or, where applicable, arranging for contractors to update and distribute the following):

**1. MassHealth Managed Care Enrollment Guide**

The MassHealth Managed Care Enrollment Guide is sent to all members newly determined eligible for MassHealth who are eligible for managed care enrollment.

The Guide has been updated to include more detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The updated Guide went into use in January, 2008.

The Defendants plan to further revise the Guide to include information about the CANS tool and the remedy services, including information about how to access those services, when those services are implemented.

**2. PCC Plan Member Handbook**

The PCC Plan member handbook is sent to all members who enroll in the PCC Plan and additional copies are available for enrolled members upon request.

The Handbook has been updated to include more detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The updated Handbook went into use in January, 2008.

The Defendants plan to further revise the Handbook to include information about the CANS tool and the remedy services, including information about how to access those services, when those services are implemented.

3. MBHP Member Handbook

The MBHP member handbook is for members who are enrolled with MBHP but not the PCC Plan (children in the care and custody of the Departments of Social Services (DSS) or Youth Services (DYS)). It includes detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The Handbook went into use for the first time in December, 2007. Hard copies were distributed to DSS and DYS in December, 2007, and an electronic copy was posted on the DSS and DYS intranet sites.

The Defendants are currently working with DSS and DYS on a plan to distribute these member handbooks more widely.

The Defendants plan to direct MBHP to further revise this Handbook to include information about the CANS tool and the remedy services, including information about how to access those services, when those services are implemented.

4. MCO Member Handbooks

Each MCO sends its own Member Handbook to members who enroll in that MCO and additional copies are available for enrolled members upon request.

Each MCO has updated its Member Handbooks to include more detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. Each MCO had completed updates to its member handbooks by February, 2008.

The Defendants plan to direct each MCO to further revise these handbooks to include information about the CANS tool and the remedy services, including information about how to access those services, when those services are implemented.

***c. Amending Member regulations, as necessary, to describe the services described in Sections I.C. and D. below and other program improvements.***

The Defendants revised relevant portions of MassHealth's All Provider regulations (130 CMR 450.000) to describe program improvements, effective December 31, 2007. For more information about these regulations, see the response to paragraph 6.a. below.

The Defendants plan to further revise MassHealth regulations, as needed, to implement the CANS tool and the remedy services, when those services are implemented.

*d .Participating in public programs, panels, and meetings with public agencies and with private advocacy organizations, such as PAL, the Federation for Parents of Children with Special Needs and others, whose membership includes MassHealth-eligible children and families.*

Since the November 30, 2007 Report on Implementation, the Defendants' Compliance Coordinator or her Assistant Director has participated in and scheduled the following public programs, panels and meetings with various stakeholders:

Trainings for Primary Care Clinicians Regarding Standardized Behavioral Health Screening (Attendance: 100-150 per training)

- November 6, 2007      Waltham
- November 8, 2007      West Springfield
- November 13, 2007      Worcester
- November 15, 2007      Taunton

Upcoming Trainings:

- June 18, 2008      Pittsfield
- June 19, 2008      Hyannis
- June 20, 2008      Danvers

Briefings for State Agency Staff and Legislators on the Rosie D. v. Romney Case, Remedy and Remedy Implementation

- Briefing for Members and Staff of the Massachusetts State Legislature, Boston, February 14, 2008
- DMH Health Planning Council, Boston, February 29, 2008
- Senior Staff, Department of Youth Services, Dorchester, March 5, 2008
- Senior Staff, Departments of Early Care and Education and Elementary and Secondary Education, Boston, March 31, 2008 and April 15, 2008
- Department of Public Health, Bureau of Substance Abuse Services, Boston, May 1, 2008

Briefings for DMH, DPH, DSS, and DYS Field Managers and Supervisors Regarding the Rosie D. Remedy and Implementation of the CANS Assessment Process (Attendance: 100-200 per training)

- April 23, 2008      Boston
- April 24, 2008      Taunton
- April 25, 2008      Tewksbury

- April 30, 2008     Springfield

Briefings for Deans and Faculty of Massachusetts' Bachelors Degree and Masters Degree Mental Health Clinician Training Programs Regarding Workforce Development.

- November 28, 2007     Boston
- March 28, 2008     Boston
- April 4, 2008 (Massachusetts Chapter of the National Association of Social Workers)  
Boston
- April 18, 2008     Boston (created ongoing working group)

Meetings with Advocates and Family and Youth Groups

- Massachusetts Coalition for Infant and Early Childhood Mental Health, Marlborough, November 9, 2007
- Lisa Lambert, Executive Director, Parent/Professional Advocacy League, Boston, November 27, 2007, April 7, 2008, and April 29, 2008
- Advocates for "Medical Homes" for children and youth with behavioral health needs, Worcester, December 20, 2007
- Full Service Schools Roundtable, Boston, January 17, 2008
- Brighton Early Childhood Mental Health System of Care, Brighton, February 4, 2008
- Committee for Children's Mental Health (Director David Keller), Worcester, February 12, 2008
- Judge Baker Center, Boston, program with Terry Cline, Ph.D., Administrator of the U.S. Substance Abuse and Mental Health Services Administration, "Child and Adolescent Mental Health Services: What the U.S. Needs", April 2, 2008
- Panel Discussion, Children's Mental Health Task Force of the Massachusetts Chapter of the American Academy of Pediatrics, Waltham, April 8, 2008
- "Partnering for Recovery", the Annual Rehabilitation and Recovery Conference, sponsored by the MBHP . Co-presented a workshop on implementation of the Remedy with Lisa Lambert, Executive Director of the Parent/Professional Advocacy League, April 30, 2008
- Department of Mental Health Statewide Youth Advisory Council, Westborough, May 20, 2008

Briefings for Providers, Family Organizations and other Stakeholders Regarding the "Request for Information" Issued in Early March (described in paragraph 38.b) (Attendance: 60-100 per briefing)

- March 11, 2008     Worcester
- March 12, 2008     Boston
- March 17, 2008     Springfield
- March 18, 2008     Plymouth

Provider Forums Co-Sponsored by the MCOs and MBHP. This two-hour forum featured presentations by the Compliance Coordinator or her Assistant Director and senior staff from Wayside Youth and Family Support Network and The Walker Home and School, both of whom currently use the CANS.

- May 7, 2008 Holyoke
- May 9, 2008 Burlington
- May 14, 2008 Worcester
- May 16, 2008 Taunton

#### Miscellaneous Meetings

- Senior Care Managers and Family Partners from the Coordinated Family Focused Care (CFFC) programs, Worcester, November 13, 2007
- Mental Health and Substance Abuse Corporations of Massachusetts, November 30, 2007, December 3, 2007, March 17, 2008, and May 30, 2008
- Dr. Katherine Grimes, M.D., Medical Director of Mental Health Services Program for Youth (MHSPY), Boston, January 8, 2008
- Senior Leadership of the Walden School, a wraparound program for deaf children and youth, Boston, January 15, 2008
- Todd Paynton, Executive Director, Black Mental Health Alliance, Boston, March 11, 2008
- Massachusetts Psychiatric Society and the New England Chapter of the American Academy of Child and Adolescent Psychiatry, Waltham, March 18, 2008
- Massachusetts Chapter of the American Academy of Pediatrics, Annual Meeting, Waltham, May 7, 2008
- The Children's League, the Massachusetts Chapter of the Child Welfare League of America, Framingham, May 19, 2008

***Paragraph 6: MassHealth Providers – The Defendants will take the following actions to educate MassHealth providers about the program improvements they are required to take under the terms of this Judgment.***

***a. Updating EPSDT regulations to reflect the program improvements described in this Judgment.***

The Defendants revised relevant portions of MassHealth's All Provider regulations (130 CMR 450.000), which include the EPSDT regulations (130 CMR 450.140-150), effective December 31, 2007. These amendments, among other things, mandate that primary care providers offer to conduct screens required in MassHealth's EPSDT Medical Protocol and Periodicity Schedule (Appendix W of the MassHealth Provider Manual); refer children for treatment when a screen reveals the need for follow-up care; and use a standardized behavioral health screening tool when conducting behavioral health screens.

***b. Updating Appendix W of the MassHealth Provider Manual, which describes medical protocols and periodicity schedules for EPSDT services, to reflect the program improvements related to screenings for behavioral health described in Section I.A.2 below.***

The Defendants have updated Appendix W to include a list of MassHealth-approved standardized behavioral health screening tools from which primary care providers must select

a tool when administering behavioral health screens for MassHealth enrolled children. The Defendants published the updated Appendix W along with the updated EPSDT regulations described in subparagraph a. above with an effective date of December 31, 2007. The Defendants plan to review the menu of approved screening tools and the schedule for behavioral health screenings periodically, in collaboration with the Massachusetts Chapter of the American Academy of Pediatrics.

***c. Drafting and distributing special provider communications related to the program improvements described in this Judgment, including how to assist MassHealth Members to access the home-based services described in Section I.D.***

The Defendants plan to evaluate the need to develop a new, stand-alone guide for MassHealth providers on how to access behavioral health services for children enrolled in MassHealth, but not enrolled in the PCC Plan or in a MassHealth-contracted MCO, which will be updated as remedy screenings, assessments and services become available.

***d. Updating and distributing existing provider education materials to reflect the program improvements described in this Judgment.***

The Defendants have updated (or have required the contractor responsible for their publication to update) the following materials that currently are distributed to providers to inform providers about using standardized behavioral health screens:

1. PCC Plan Provider Newsletters – The PCC Plan included articles in the December, 2007 and March, 2008 issues of its provider newsletter that include information on the requirement for PCCs to use standardized behavioral health screening tools.
2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Preventive Pediatric Health-care Screening and Diagnosis (PPHSD) Services Billing Guidelines for MassHealth Physicians and Mid-level Providers – The Defendants have updated this Guide for providers who bill MassHealth directly for EPSDT and PPHSD screening services. The updated Guide became available in December, 2007
3. PCC Plan Provider Contract – The Defendants updated this contract and mailed the updated contract to enrolled Primary Care Clinicians in January, 2008.
4. PCC Plan Provider Handbook – The Defendants updated this Handbook for providers who are enrolled as PCCs. The updated Handbook was mailed to all enrolled PCCs with the updated PCC Plan provider contract.
5. MCO newsletters – Each MassHealth-contracted MCO included articles in their respective MCO provider newsletters to inform providers about the requirement for using standardized behavioral health screening tools. These newsletters were published between November, 2007 and January, 2008.

6. MassHealth “Update” article – MassHealth included articles containing information for providers about using standardized behavioral health screening tools in MassHealth “Update”, which is MassHealth’s online newsletter to all MassHealth providers. These articles were published in December, 2007, and February, 2008.

The Defendants are in the process of assessing which of the above materials, or additional materials that are distributed to providers, need to be updated to inform providers about the standardized assessment process using the CANS tool. The Defendants will assess which materials need to be updated to inform providers about the remedy services, including how to access those services once those services are implemented.

***e. Expanding distribution points of existing materials regarding EPSDT generally, including the program improvements described in this Judgment.***

The Defendants created a website for the Children’s Behavioral Health Initiative (CBHI) that is available on the EOHHS website to provide information to MassHealth providers, MassHealth members, the broader community of human service providers, and members of the general public about EPSDT generally and the program improvements that the Defendants are making in response to the Judgment. (CBHI is the name that EOHHS has given to the activities to implement the Final Judgment in this case.)

The CBHI webpage became available in December 2007. To date, the Defendants have posted on this website many of the materials referenced in the paragraphs above and below that describe the requirement for primary care providers to use standardized behavioral health screening tools, including:

- EPSDT member notices described in paragraph 3
- Member notice described in paragraph 5.a
- PCC Plan Member Handbook described in paragraph 5.b
- MBHP Member Handbook in paragraph 5.b
- MCO Member Handbooks in paragraph 5.b
- EPSDT regulations described in paragraphs 5.c and 6.a and Appendix W described in paragraphs 6.b
- The fact sheets described in paragraph 7.b
- EPSDT Billing Guide described in paragraph 6.d

The Defendants have also posted certain court documents and other information about the Defendants’ implementation efforts, including information about provider trainings on the behavioral health screening tools and CANS tool.

The Defendants plan to update this website to include additional information and additional links to materials that describe the CANS tool, once the tool has been implemented; and (ii) the remedy services, including how to access those services, once they are implemented.

***f. Implementing any other operational changes required to implement the program improvements described in this Judgment.***

The Defendants have implemented changes to the Medicaid Management Information System (MMIS) to allow MassHealth primary care providers to be reimbursed for the administration and scoring of the standardized behavioral health screening tools, and to allow the Defendants to track the rate at which providers are utilizing a standardized behavioral health screening tool when administering behavioral health screens. The Defendants will implement other operational changes that are identified as necessary to implement the projects described in the Judgment.

***g. Holding special forums for providers to encourage clinical performance activities consistent with the principles and goals of this Judgment.***

The Defendants conducted four forums for primary care providers to educate these providers about the requirement to offer to use a standardized behavioral health screening tool when screening children for behavioral health issues. These forums took place on November 6, 8, 13 and 15, in Taunton, Springfield, Waltham and Worcester. Additional forums for primary care providers to address the behavioral health screening requirements will be held on June 18, 19 and 26, 2008 in Pittsfield, Hyannis and Danvers.

As mentioned in Paragraph 5, the MCOs and MBHP have sponsored four forums for behavioral health providers featuring presentations by the Compliance Coordinator or her Assistant Director and senior staff from Wayside Youth and Family Support Network and The Walker Home and School (both of who currently use the CANS) to describe how the CANS tool can be used to promote family-centered behavioral healthcare for children and adolescents. These forums were held in Holyoke, May 7; Burlington, May 9; Worcester, May 14; and Taunton, May 16.

The defendants also have made expert consultation available, free of charge, to primary care providers who have clinical or administrative questions regarding use of the standardized behavioral health screening instruments in their practices, through the Massachusetts Child Psychiatry Access Program that is administered for EOHHS by MBHP.

***h. Amending MassHealth's managed care contracts to assure that all such entities educate the providers in their network about the program improvements described in this Judgment, as described in Paragraphs 6.a.-g. above.***

The Defendants have executed amendments to its contracts with MBHP and the MCOs to specifically require them to educate their network providers about the program improvements described in sections a. through g. of this paragraph.

***i. Coordinating these efforts with the "Virtual Gateway," which is the EOHHS system for web-based, online access to programs, including MassHealth and related benefit programs such as food stamps, and which allows a wide array of hospitals, community health centers, health and human services providers, and other entities to assist children and families in enrolling in MassHealth.***

As described in paragraph 6.e, the Defendants have created a Children's Behavioral Health Initiative (CBHI) webpage that is available on the EOHHS website to inform MassHealth providers, MassHealth members, the broader community of human services providers, and members of the public about EPSDT generally and the program improvements that the Defendants are making in response to the Judgment. The Defendants plan to update this website as implementation of the Judgment proceeds.

Additionally, as more fully described in paragraph 39.b, the Defendants are developing a web-based CANS Certified Assessor Training and Certification Application to facilitate CANS training and certification for behavioral health clinicians, and a web-based CANS Application that will be available through the Virtual Gateway for behavioral health providers who are required to use the CANS tool

***Paragraph 7: The Public - To improve public information about the program improvements the Defendants are required to take under the terms of this Judgment, the Defendants will take the following actions to present the terms of this Judgment to public and private agencies that serve children and families:***

***a. Presenting the Judgment to appropriate Commonwealth officials in the Executive Branch and the Legislature.***

The Defendants have conveyed copies of the Remedial Plan or Proposed Judgment to senior managers in:

- the Executive Office of Administration and Finance;
- the Executive Office of Health and Human Services;
- the Office of Medicaid; and
- the Departments of Mental Health, Mental Retardation, Public Health, Social Services and Youth Services.

A copy of the Judgment was included with a copy of the November 30, 2007 Report on Implementation and was sent to:

- the Senate President;
- the Speaker of the House;
- the Chairs of the Senate and House Committees on Ways and Means and the Senate and House Chairs of the Joint Committees on: Health Care Financing; Mental Health and Substance Abuse; and Children and Families
- the Secretary of Administration and Finance;
- the Secretary of Health and Human Services and her senior management staff;
- the Medicaid Director;
- the Commissioner of the Division of Health Care Finance and Policy; and
- the Commissioners of the Departments of: Education, Early Education and Care, Mental Health, Mental Retardation, Public Health, Social Services and Youth Services.

***b. Creating new pamphlets, informational booklets, fact sheets, and other outreach materials describing these improvements.***

The Defendants developed and distributed two notices, in the form of ‘fact sheets’, for the purposes of outreach. ‘Fact Sheet 1’ is for the general public. ‘Fact Sheet 2’ is for agencies/groups that work with children and whose staff are likely to help parents learn about and access needed screenings, assessments and services for their children. Both Fact Sheets contain information about EPSDT services available to children enrolled in MassHealth. The Defendants plan to update these Fact Sheets in the future to provide more information about the CANS tool and the remedy services, including information on how to access those services, when those services are implemented.

The Defendants distributed ‘Fact Sheet 1’ to the Massachusetts Medical Society, the Massachusetts League of Community Health Centers, the Massachusetts Chapter of the American Academy of Pediatrics, the Massachusetts Association of Family Practitioners, and the Mental Health and Substance Abuse Corporation of Massachusetts in December 2007, requesting each organization to make the materials available to their provider networks and to encourage their provider networks to circulate the materials to their patients and families.

The Defendants distributed ‘Fact Sheet 1’ and ‘Fact Sheet 2’ to staff working with the following agencies/groups in December 2007, requesting that each agency/group distribute ‘Fact Sheet 2’ to their respective staff/provider groups and encourage their staff/provider groups to circulate ‘Fact Sheet 1’ to their clients:

- Department of Social Services
- Department of Youth Services
- Department of Mental Health
- Department of Transitional Assistance
- Office for Refugees and Immigrants
- Department of Early Education and Care
- Department of Public Health
- Department of Education

***c. Developing and implementing training programs for line staff at the Departments of Mental Health, Social Services, Youth Services, Mental Retardation, Transitional Assistance, and the Office for Refugees and Immigrants on how to access MassHealth services for children with SED.***

The Defendants distributed ‘Fact Sheet 1’ and ‘Fact Sheet 2’ to agency line staff at the agencies noted above. See paragraph 7.b above for more details. These fact sheets will be updated to include information about MassHealth services, including the new services required by the Judgment, as these services are implemented.

As discussed in Paragraph 5, briefings for State Agency Field Managers and Supervisors regarding the remedy and implementation of the CANS were held during April, 2008 in Boston, Springfield, Taunton and Tewksbury. Approximately 100-200 staff from the

Departments of Mental Health, Public Health, Social Services and Youth Services attended each training. The Defendants will be working with the training directors of each of the named state agencies to develop and implement training of line staff on how to access MassHealth services for children with SED.

- d. Distributing outreach materials in primary care settings, community health centers, and community mental health centers and posting electronic materials on the EOHHS Virtual Gateway that are designed to provide information to MassHealth Members and to public and private agencies that come in contact with or serve children with SED or their families.***

The Defendants will continue to coordinate with the associations for these provider types to ensure that updated versions of 'Fact Sheet 1' are made available to the public at provider sites.

For more information about the Virtual Gateway, see the response to paragraph 6.i. above.

- e. Working with the Department of Early Education and Care to educate preschools, childcare centers and Head Start Programs on how to access MassHealth services for children with SED.***

The Department of Early Education and Care (DEEC) distributed the Fact Sheets to all childcare providers in the Commonwealth. The Defendants will continue to work with DEEC on strategies to inform childcare providers and the families and children they serve about behavioral health screenings, CANS assessments and services for their children.

- f. Working with the Department of Education, the Department of Public Health and Public School Districts to educate school nurses and other school personnel on how to access MassHealth services for children with SED.***

As mentioned in Paragraph 5, the Defendants have had three meetings with the Departments of Early Education and Care (DEEC) and Elementary and Secondary Education (DESE). This has resulted in the creation of a staff planning group which will develop and implement strategies for communicating necessary information about the remedy, the remedy services and how to access them to child care providers and school personnel, including Superintendents, Special Education Directors, School Counselors and School Nurses.

***Paragraph 8: The Defendants will require primary care providers who perform periodic and medically necessary inter-periodic screenings pursuant to 42 U.S.C. §1395d(r)(1) to select from a menu of standardized behavioral health screening tools. The menu of standardized tools will include, but not be limited to, the Pediatric Symptom Checklist (PSC) and the Parents' Evaluation of Developmental Status (PEDS). Where additional screening tools may be needed, for instance to screen for autistic conditions, depression or substance abuse, primary care providers will use their best clinical judgment to determine which of the approved tools are appropriate for use.***

As explained in response to paragraph 6.a. above, effective December 31, 2007, the Defendants updated MassHealth regulations governing the EPSDT program (130 CMR 450.140-150) to require primary care providers who perform periodic and medically necessary inter-periodic screenings pursuant to 42 USC 1395d(r)(1) to select from a menu of standardized behavioral health screening tools.

As explained in paragraph 6.b. above, the menu of approved screening tools, which includes the Pediatric Symptom Checklist (PSC) and the Parents' Evaluation of Developmental Status (PEDS), as well as other tools to screen for autistic conditions, depression or substance abuse appears in Appendix W of the MassHealth Provider Manual, which became effective December 31, 2007.

***Paragraph 9: The Defendants will amend pertinent MassHealth provider regulations to clarify that all primary care providers, whether they are paid through the managed-care or the fee-for-service system, are required to provide periodic and inter-periodic screens.***

As explained in paragraph 6.a. above, the Defendants have updated MassHealth regulations governing the EPSDT program (130 CMR 450.140-150) effective December 31, 2007 to clarify that all primary care providers are required to provide periodic and medically necessary inter-periodic screens.

***Paragraph 10: There will be a renewed emphasis on screening, combined with ongoing training opportunities for providers and quality improvement initiatives directed at informing primary care providers about the most effective use of approved screening tools, how to evaluate behavioral health information gathered in the screening, and most particularly how and where to make referrals for follow-up behavioral health clinical assessment. Additional quality improvement initiatives will include improved tracking of delivered screenings and of utilization of services delivered by pediatricians or other medical providers or behavioral health providers following a screening and use of data collected to help improve delivery of EPSDT screening, including assuring that providers offer behavioral health screenings according to the State's periodicity schedule and more often as requested (described in Section I.E.2).***

As described in paragraph 6.g, the Defendants held a series of provider training forums on November 6, 8, 13, and 15, 2007, to inform primary care providers about the most effective use of the approved screening tools, to educate them on how to evaluate behavioral health information gathered during the screening, and to provide information on how and where they can refer members needing further behavioral health clinical assessment. Additional forums covering the same topics for primary care providers will be held on June 18, 19, and 26, 2008 in Pittsfield, Hyannis and Danvers.

The Defendants are tracking the number of delivered behavioral health screenings and are developing a plan for updating existing systems and methods to allow the Defendants to track the utilization of services following a screening. The Defendants plan to monitor the data gathered from such systems and use the data to help improve delivery of EPSDT screening, including

assuring that providers offer behavioral health screenings according to the State's periodicity schedule.

**Paragraph 11:** *MassHealth will continue the practice of not requiring a primary care visit or EPSDT screening as a prerequisite for an eligible child to receive MassHealth behavioral health services. MassHealth-eligible children and eligible family members can be referred or can self-refer for Medicaid services at any time by other, including other EOHHS agencies, state agencies, public schools, community health centers, hospitals and community mental health providers.*

The Defendants do not plan to change their policy that all MassHealth members, regardless of their managed care enrollment status, may access behavioral health services without the need for a referral as a prerequisite for receiving services. MassHealth-eligible children and eligible family members can continue to be referred, or to self-refer, for Medicaid services at any time by others, including other EOHHS agencies, state agencies, public schools, community health centers, hospitals and community mental health providers.

**Paragraph 12:** *The Defendants will provide information, outreach and training activities, focused on such other agencies and providers. In addition, the Defendants will develop and distribute written guidance that establishes protocols for referrals for behavioral health EPSDT screenings, assessments, and services, including the home-based services described in Section I.D., and will work with EOHHS agencies and other providers to enhance the capacity of their staff to connect children with SED and their families to behavioral health EPSDT screenings, assessments, and medically necessary services.*

As described in the response to paragraph 7 above, the Defendants have developed and distributed written guidance that establishes protocols for referrals for screenings. The Defendants are in the process of developing policies with the child-serving state agencies to guide their staff in accessing screening services, clinical assessments and the remedy services.

**Paragraph 13:** *The Defendants will ensure that EPSDT services include a clinical assessment process for eligible children who may need behavioral health services, and will connect those assessments to a treatment planning process as follows:*

This paragraph is introductory; see detailed response below.

**Paragraph 14:** *The Defendants will require a clinical behavioral health assessment in the circumstances described below by licensed clinicians and other appropriately trained and credentialed professionals.*

As of November 31, 2008, MassHealth will require behavioral health clinicians who serve MassHealth members on a fee-for-service basis to utilize a CANS tool when they provide clinical assessments including the initial clinical assessment and, at a minimum, every 90 days during the course of treatment. MassHealth will require MCOs and MBHP to require their networks to do the same. The steps that the Defendants are taking to require that the assessment

using the CANS tool be conducted by licensed clinicians and other appropriately trained and credentialed professionals is described in response to paragraph 16.b. below.

**Paragraph 15:** *In addition to the clinical assessment, the Defendants will require providers to use the standardized clinical information collection tool known as the Child and Adolescent Needs and Strengths (CANS) as an information integration and decision support tool to help clinicians and other staff in collaboration with families identify and assess a child's behavioral health needs. Information obtained through the CANS process provides a profile of the child which trained clinicians use in conjunction with their clinical judgment and expertise to inform treatment planning and to ensure that treatment addresses identified needs.*

The Defendants convened a workgroup, which met regularly in 2006 and 2007 with John Lyons, Ph.D., developer of the CANS tool. The group included representatives from MassHealth, the Department of Mental Health (DMH), the Department of Youth Services (DYS), the Department of Social Services (DSS), the Office of Clinical Affairs (OCA), the Commonwealth Medicine Division of the University of Massachusetts Medical School, the Department of Public Health (DPH), and a child psychiatrist. The workgroup developed a Massachusetts CANS tool in two forms: one form for children under the age of five and another form for children and adolescents ages five to 21.

The Defendants presented draft versions of the Massachusetts CANS tool to providers, families and the Plaintiffs to gather their input. Both forms of the CANS tool are now complete.

In addition, EOHHS developed a cover sheet to accompany both forms of the CANS tool, that requires the clinician to identify whether the member has a serious emotional disturbance. This cover sheet was provided to the Plaintiffs for review and comment.

**Paragraph 16:** *The Defendants will implement an assessment process that meets the following description:*

- a. In most instances, the assessment process will be initiated when a child presents for treatment to a MassHealth behavioral health clinician following a referral by the child's primary care physician based on the results of a behavioral health screening. However, there are other ways for children to be referred for mental health services. A parent may make a request for mental health services and assessment directly to a MassHealth-enrolled mental health provider, with or without a referral. A child may also be referred for assessment and services by a provider, a state agency, or a school that comes into contact with a child and identifies a potential behavioral health need.*

The Defendants will be requiring behavioral health providers who serve MassHealth-enrolled children to conduct an assessment and record the results using the Massachusetts CANS tool when a child presents for treatment, whether the child's visit follows a behavioral health screening and referral from a primary care provider; whether the child presents following a referral from a provider, state agency, or school; or whether the child presents without a referral.

- b. Assessment typically commences with a clinical intake process. As noted, Defendants will require MassHealth providers to use the CANS as a standardized tool to organize information gathered during the assessment process. Defendants will require trained MassHealth behavioral health providers to offer a clinical assessment to each child who appears for treatment, including a diagnostic evaluation from a licensed clinician.***

Behavioral health clinicians who use the CANS tool will be required to be trained and certified on the use of the CANS tool, whether they serve MassHealth members on a fee-for-service basis or participate in the network of an MCO or MBHP. To be certified, they will be required to pass a certification examination that has been approved by John Lyons. Clinicians who fail to attain a passing score will have opportunities to retake the certification examination. Recertification will be required every two years.

The Defendants executed an Interdepartmental Service Agreement (ISA) with the Commonwealth Medicine Division of the University of Massachusetts to assist in developing the CANS certification training and examination program, in collaboration and consultation with Dr. John Lyons. The training program includes both in-person trainings with continuing education unit (CEU) credits and also a web-based training opportunity.

The Defendants started providing the in-person trainings in May, 2008. The trainings will be taking place regularly. The web-based training will be available starting in July, 2008. The Defendants are in the process of amending MassHealth regulations, provider contracts, and interagency service agreements, as necessary, to require that appropriate clinicians use the Massachusetts CANS tool as described in this Judgment. As noted in paragraph 15 above, the Defendants will require that clinical assessments using the CANS tool include a diagnostic opinion whether the member has a serious emotional disturbance. The cover sheet of both forms of the Massachusetts CANS tool will provide a space for clinicians to record this opinion.

- c. The assessment process leads to a clinical diagnosis and the commencement of treatment planning. During the assessment process, medically necessary services are available to the child, including, but not limited to, crisis services and short-term home based services, pending completion of the assessment and the development of the treatment plan.***

The assessment process, as described in paragraphs 15 and 16.a above, will lead to a clinical diagnosis and the commencement of treatment planning. While the assessment process and treatment planning process is underway, medically necessary MassHealth-covered services will be available.

- d. As described in more detail in Section I.C. below, upon referral to the Intensive Care Coordination process, an intensive, home-based assessment and treatment planning process will take place, organized by a care manager and with the involvement of the child's family and other community supports.***

Providers of Intensive Care Coordination will utilize the CANS tool as part of the intensive home-based assessment and treatment planning process. A diagnostic determination will include whether the Member has a serious emotional disturbance. The cover sheet of both forms of the Massachusetts CANS tool will provide a space for clinicians to record their diagnostic determination.

- e. The assessment process described here, including the use of the CANS where appropriate, will be required as part of discharge planning for children who have been identified as having behavioral health problems who are being discharged from acute inpatient hospitals, community based acute treatment settings (CBATS), from Department of Mental Health (DMH) intensive residential settings, and DMH continuing care programs, with the goal of identifying children for whom Intensive Care Coordination services may be appropriate. For those identified children, a referral for those services will be a component of a discharge treatment plan.*

MassHealth is continuing to develop its approach to the assessment process in acute inpatient hospitals, community based acute treatment settings, DMH intensive residential settings and DMH continuing care programs, to ensure the use of the CANS to support discharge planning is appropriate, effective and reliable. MassHealth is engaged in discussions with John Lyons, other experts, providers, including state agencies, acute inpatient hospital and other providers of MassHealth reimbursed twenty-four hour services and the Plaintiffs in its implementation of this provision of the Order.

**Paragraph 17:** Deleted.

**Paragraph 18:** Deleted.

**Paragraph 19:** *The Defendants will provide Intensive Care Coordination to children who qualify based on the criteria set forth above and who choose to have Intensive Care Coordination including a Care Manager, who facilitates an individualized, child-centered, family focused care planning team, as follows:*

This paragraph is introductory; see detailed response below.

**Paragraph 20:** *The role of the Care Manager is to coordinate multiple services that are delivered in a therapeutic manner, allowing the child to receive services in accordance with his or her changing needs. Additionally, the Care Manager is responsible for promoting integrated services, with links between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.*

See response to paragraph 38 below.

**Paragraph 21:** *The basic responsibilities of Care Managers are: (1) assisting in the identification of other members of the care planning team; (2) facilitating the care planning team in identifying the strengths of the child and family, as well as any community supports and other resources; (3) convening, coordinating, and communicating with the care planning*

*team; (4) working directly with the child and family; (5) collecting background information and plans from other agencies, subject to the need to obtain informed consent; (6) preparing, monitoring, and modifying the individualized care plan in concert with the care planning team; (7) coordinating the delivery of available services; (8) collaborating with other caregivers on the child and family's behalf; and (9) facilitating transition planning, including planning for aftercare or alternative supports when in-home support services are no longer needed.*

See response to paragraph 38 below.

**Paragraph 22:** *The Care Manager will either be a licensed mental health professional or will provide care management under the supervision of a licensed mental health professional. S/he will be trained in the “wraparound” process for providing care within a System of Care. The “wraparound process” refers to a planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child to achieve a positive set of outcomes. The System of Care is a cross-system coordinated network of services and supports organized to address the complex and changing needs of the child. This process will be consistent with the principles and values of the Child-Adolescent Services System Program (CASSP) which encourages care provision to be strength-based, individualized, child-centered, family-focused, community-based, multi-system, and culturally competent.*

See response to paragraph 38 below.

**Paragraph 23:** *The care planning team will be family-centered and include a variety of interested persons and entities, as appropriate, such as family members (defined as any biological, kinship, foster and/or adoptive family member responsible for the care of the child), providers, case managers from other state agencies when a child has such involvement, and natural supports such as neighbors, friends, and clergy.*

See response to paragraph 38 below.

**Paragraph 24:** *The care planning team will use multiple tools, including a CANS standardized instrument, in conjunction with a comprehensive psychosocial assessment, as well as other clinical diagnoses, to organize and guide the development of an individualized plan of care that most effectively meets the child's needs. This plan of care will be reviewed periodically and will be updated, as needed, to reflect the changing needs of the child. As part of this process, further assessments, including re-assessments using the CANS or other tools, may be conducted so that the changing needs of the child can be identified.*

See response to paragraph 38 below.

**Paragraph 25:** *The care planning team will exercise the authority to identify and arrange for all medically necessary services needed by the eligible child with SED, consistent with the overall authority of MassHealth to establish reasonable medical necessity criteria, set reasonable standards for*

*prior authorization, and conduct other utilization management activities authorized under the Medicaid Act, and the obligation of all direct service providers to assure that the services they deliver are medically necessary.*

See response to paragraph 38 below.

**Paragraph 26:** *The findings of the care planning team will be used to guide the treatment planning process. The individualized care plan is the primary coordinating tool for therapeutic interventions and service planning. The care planning team, facilitated by the Care Manager, will be responsible for developing and updating, as needed, the individualized care plan that supports the strengths, needs, and goals of the child and family and incorporating information collected through initial and subsequent assessment. The individualized care plan will also include transition or discharge plans specific to the child's needs.*

See response to paragraph 38 below.

**Paragraph 27:** *The care and treatment planning process will be undertaken pursuant to guidelines and standards developed by EOHHS, which will ensure that the process is methodologically consistent and appropriately individualized to meet the needs of the child and family. EOHHS, in consultation with DMH, will develop an operational manual that includes these guidelines and standards for the use of the care planning teams.*

See response to paragraph 38 below.

**Paragraph 28:** *Each individualized care plan will: (1) describe the child's strengths and needs; (2) propose treatment goals, objectives, and timetables for achieving these goals and objectives, including moving to less intensive levels of service; (3) set forth the specific services that will be provided to the child, including the frequency and intensity of each service; (4) incorporate the child and family's crisis plan; and (5) identify the providers of services.*

See response to paragraph 38 below.

**Paragraph 29:** *Individualized care plans will be reviewed as needed, but at least monthly by the Care Manager and quarterly by the care planning team. In addition, such review will be undertaken when there is a change in another EOHHS agency's plan for the child.*

See response to paragraph 38 below.

**Paragraph 30:** *Intensive care coordination services are particularly critical for children who are receiving services from EOHHS agencies in addition to MassHealth. In order to assure the success of the care planning team process and the individualized care plan for a child with multiple agency involvement, EOHHS will ensure that a representative of each such EOHHS agency will be a part of the child's care planning team. Operating pursuant to protocols developed by EOHHS, EOHHS agency representatives will coordinate any agency-specific planning process or the content of an agency-specific treatment plan as members of the care*

*planning team. EOHHS will develop a conflict-resolution process for resolving disagreements among members of the team.*

See response to paragraph 38 below.

***Paragraph 31:*** *For MassHealth Members entitled to EPSDT services, the Defendants will cover the following services for Members who have SED when such services are medically necessary, subject to the availability of Federal Financial Participation (“FFP”) under 42 U.S.C. § 1396d(a) and other requisite federal approvals: assessments, including the CANS described in Section I.B above, the Intensive Care Coordination and Treatment Planning described in Section I.C above, and the services described in more detail below in this Section I.D. More detailed service descriptions will be developed later to assist in establishing billing codes, procedures and rates, and may be necessary or advisable for the process of seeking CMS approval of these services. EOHHS, in consultation with DMH, will collaborate with interested stakeholders (including clinical experts, child and family advocates, and managed care partners) in the development of clinical criteria for each of the covered services below.*

See response to paragraph 38 below.

***Paragraph 32:*** *The components of this service category will include Mobile Crisis Intervention and Crisis Stabilization:*

- a. Mobile Crisis Intervention - A mobile, on-site, face-to-face therapeutic response to a child experiencing a mental health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation in community settings (including the child’s home) and reducing the immediate risk of danger to the child or others. Mobile crisis services may be provided by a single professional crisis worker or by a team of professionals trained in crisis intervention. Services are available 24 hours a day, 7 days a week. Phone contact and consultation may be provided as part of the intervention. Providers are qualified licensed clinicians or, in limited circumstances, qualified paraprofessionals supervised by qualified, licensed clinicians.*

***FN Text:*** *Where provider qualifications appear in the description of the services in this section of the Judgment, the following applies: As used in this Judgment, the terms “qualified, licensed clinician” and “qualified paraprofessional” refer to individuals with specific licensure, education, training, and/or experience, as will be set forth in standards to be established by the Defendants. Such individuals will be authorized to provide specific services referred to herein. A licensed clinician is an individual licensed by the Commonwealth to provide clinical services within a particular scope as defined by the applicable licensing authority or statute, including, but not necessarily limited to, physicians, psychiatrists, licensed clinical psychologists, licensed independent clinical social workers, licensed clinical social workers, and licensed mental health counselors. A paraprofessional is an individual who, by virtue of certification, education, training, or experience is qualified to provide therapeutic services under the supervision of a licensed clinician.*

See response to paragraph 38 below.

- b. Crisis Stabilization - Services designed to prevent or ameliorate a crisis that may otherwise result in a child being hospitalized or placed outside the home as a result of the acuity of the child's mental health condition. Crisis stabilization staff observe, monitor, and treat the child, as well as teach, support, and assist the parent or caretaker to better understand and manage behavior that has resulted in current or previous crisis situations. Crisis stabilization staff can observe and treat a child in his/her natural setting or in another community setting that provides crisis services, usually for 24-72 hours but up to 7 days. Crisis stabilization staff are qualified licensed clinicians and qualified paraprofessionals supervised by qualified licensed clinicians. Crisis stabilization in a community setting is provided by crisis stabilization staff in a setting other than a hospital or a Psychiatric Residential Treatment Facility (PRTF) and includes room and board costs.*

See response to paragraph 38 below.

***Paragraph 33:*** *The components of this service category are In-Home Behavioral Services (including behavior management therapy and behavior management monitoring), In-Home Therapy Services (including a therapeutic clinical intervention and ongoing training and therapeutic support), and Mentor Services (including independent living skills mentors and child/family support mentors). While the services in this category may be provided where clinically appropriate, it is intended that they be provided in any setting where the child is naturally located, including, but not limited to, the home (including foster homes and therapeutic foster homes), child-care centers, respite settings, and other community settings. These services may be provided as a bundled service by a team or as a discrete clinical intervention depending upon the service needs of the child.*

See response to paragraph 38 below.

- a. In-home Behavioral Services - Behavioral services usually include a combination of behavior management therapy and behavior management monitoring, as follows:*
  - (i) Behavior management therapy is provided by a trained professional, who assesses, treats, supervises, and coordinates interventions to address specific behavioral objectives or performance. Behavior management therapy addresses challenging behaviors which interfere with the child's successful functioning. The therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, that are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and the level of intervention required. Behavior management therapy is provided by qualified licensed clinicians.*
  - (ii) Behavior management monitoring is provided by a trained behavioral aide, who implements and monitors specific behavioral objectives and interventions developed by the behavior management therapist. The aide may also monitor the child's*

*behavior and compliance with therapeutic expectations of the treatment plan. The aide assists the therapist to teach the child appropriate behaviors, monitors behavior and related activities, and provides informal counseling or other assistance, either by phone or in person. Behavior management monitoring is provided by qualified paraprofessionals supervised by qualified licensed clinicians.*

See response to paragraph 38 below.

***b. In-home Therapy Services – Therapy services include a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:***

- (i) A structured, consistent, therapeutic relationship between a licensed clinician and the family and/or child for the purpose of meeting specific emotional or social relationship issues. The licensed clinician, in conjunction with the care planning team, develops and implements therapy goals and objectives which are incorporated into the child's treatment plan. Clinical services are provided by a qualified licensed clinician who will often work in a team that includes a qualified paraprofessional who is supervised by the qualified licensed clinician.***
- (ii) Ongoing therapeutic training and support to the child/adolescent to enhance social and communication skills in a variety of community settings, including the home, school, recreational, and vocational environments. All services must be directly related to the child's treatment plan and address the child's emotional/social needs, including family issues related to the promotion of healthy functioning and feedback to the family. This service is provided by a qualified paraprofessional who is supervised by the qualified licensed clinician. This paraprofessional may also provide behavior monitoring as described above.***

See response to paragraph 38 below.

***c. Mentor Services – Mentor services include:***

- (i) Independent Living Skills Mentors provide a structured, one-to-one relationship with an adolescent for the purpose of addressing daily living, social, and communication needs. Each adolescent who utilizes an Independent Living Skills Mentor will have independent living goals and objectives developed by the adolescent and his/her treatment team. These goals and objectives will be incorporated into the adolescent's treatment plan. Mentors are qualified paraprofessionals and are supervised by a qualified licensed clinician.***
- (ii) Child/Family Support Mentors provide a structured, one-to-one relationship with a parent(s) for the purpose of addressing issues directly related to the child's emotional and behavioral functioning. Services may include education, support, and training for the parent(s) to address the treatment plan's behavioral health goals and objectives for the child. Areas of need may include parent training on the development and implementation of behavioral plans. Child/Family Support***

*Mentors are qualified paraprofessionals and are supervised by a licensed qualified clinician.*

See response to paragraph 38 below.

**Paragraph 34:** *The Defendants will systematically execute the program improvements described in Sections I.A-D above, including a defined scheme for monitoring success, as follows. The description below of the steps that Defendants will take to implement this Judgment is subject to modification during the course of implementation in accordance with Section II below.*

This paragraph is introductory; see detailed response below.

**Paragraph 35:** *The Defendants will implement this Judgment as a dynamic process involving multiple concurrent work efforts. Those efforts will be organized into four main projects, described below, which encompass all aspects of the program improvements contained in this Judgment. This Judgment assigns a timelines for implementing each project, which are subject to modification for good cause upon application of either party. It is important to note that certain elements of each project are subject to external factors that are not fully within the control of EOHHS.*

This paragraph is introductory; see detailed response below.

**Paragraph 36:** *Project 1: Behavioral Health Screening, Informing, and Noticing Improvements:*

- a. Project Purpose: Implementation of improvements to behavioral health screening and clear communication of new requirements about the use of standardized screening tools.*

This section is a purpose statement, and requires no response.

- b. Tasks performed will include:*

- (i) Developing and announcing a standardized list of behavioral health screening tools.*
- (ii) Drafting managed-care or provider contract amendments and regulatory changes to conform to the new requirements.*
- (iii) Improving EPSDT Member notices concerning the availability of behavioral health and other EPSDT screening, and the availability of behavioral health services.*

For a response to subparagraph i.), see in the response to paragraphs 6 and 8 above.

For a response to subparagraph ii.), see the response to paragraphs 4, 5(b), 6(d),(g), and (h) above.

For a response to subparagraph iii.), see the response to paragraph 3 above.

***c. Timelines for implementation:***

- (i) Defendants will submit to the Court a written report on the implementation of Project 1 no later than June 30, 2007.***
- (ii) Completion of this project will be by December 31, 2007.***

The Defendants submitted a report dated June 27, 2007, that fulfilled the requirement in subpart i. The Defendants took the steps described in paragraphs 2-12 above to complete this project.

**Paragraph 37: Project 2: CANS Development, Training and Development**

- a. Project Purpose: To design a statewide common assessment information gathering tool, the CANS, for statewide use, and to train behavioral health providers in its appropriate use.***

This section is a purpose statement, and requires no response.

***b. Task performed will include:***

- (i) developing a Massachusetts-specific short and long form CANS in conjunction with Developer John Lyons;***
- (ii) training behavioral health providers to complete and use the CANS tool, including EOHHS-required data gathering techniques; and***
- (iii) drafting managed-care and provider contract amendments and regulatory changes to conform with the new requirements.***

See the response to paragraphs 15-16 above.

***c. Timelines for implementation:***

- (i) Defendants will submit to the Court a preliminary report with regard to the completion of Project 2 no later than November 30, 2007; and***
- (ii) Completion of this project will be by November 30, 2008.***

The Defendants submitted a report dated November 30, 2007 that fulfilled the requirement in subpart i. The Defendants are taking the steps described in paragraphs 13-16 above to complete this project by November 30, 2008, as required by subpart ii.

**Paragraph 38: Development of a Service Delivery Network**

- a. Project Purpose: Plan, design, and contract for a service delivery network to deliver the services described in this Judgment.***

This section is a purpose statement, and requires no response.

- b. Basic Project Description: EOHHS, and DMH, will engage in a process of network design and development that is directed and managed by EOHHS and DMH toward establishing a statewide network of community service agencies (“CSAs”), common across all MassHealth payers, to the extent feasible, and responsible for coordinating and providing or arranging for medically necessary home-based services.*

*Although a number of mechanisms are available to EOHHS, and DMH, to design and approve this system, the initial, phased network development process will be implemented through the existing Medicaid managed care behavioral health contractor under the direction of EOHHS in consultation with DMH. EOHHS, and DMH, will establish standards for CSAs that will include provider qualifications, service delivery standards, training requirements, documentation requirements, utilization management standards, and performance measures. EOHHS will amend its managed care behavioral health contract to require the behavioral health contractor to procure a network of CSAs that meets the standards established by EOHHS, and DMH.*

*CSAs will be providers included in the networks of MassHealth’s contracted managed care entities and its fee-for-service network. All MassHealth payers, including MassHealth’s managed care organizations (“MCOs”) and the managed care behavioral health contractor, will offer to contract with the same entities as CSAs, subject to successful negotiations and EOHHS’ determination that such entities have the capacity to serve the managed care entities’ expected MassHealth enrollment. The current expectation is that the Medicaid fee-for-service population will have access to the same providers as the Medicaid managed care population.*

*CSAs will operate in service areas that will be defined by EOHHS, and DMH, with the following objectives in mind: that CSA service areas be generally consistent with DMH sites; that they promote consistency with DSS Family Networks provider areas; that they promote consistency, capacity, and efficiency; that they reflect linguistic or cultural characteristics, as appropriate; and that they reflect natural service areas. The current expectation is that there will be one CSA in each area so 21 defined, and that in total there will be no fewer than 15, and may be as many as 30, CSA service areas. The Defendants will consider defining regions for certain functions.*

*CSAs may deliver the clinical assessment services described above in Section I.B.1 and the intensive care coordination services described above in Sections I.B.2 and I.C. CSAs will either deliver or, as a component of intensive care coordination, assist MassHealth Members to access the services described above in Section I.D. CSAs will be responsible for assisting Members to access all services described in this Judgment that they do not themselves provide.*

### **Implementation Management Structure**

Since the November 30, 2007 Report on Implementation, the Defendants have reconfigured their implementation management structure to reflect the accelerating shift from policy development to program implementation. Therefore, the following workgroups and executive structure now exist:

Children's Behavioral Health Initiative (CBHI) Executive Committee

Convened by: Barbara Leadholm, Commissioner of the Department of Mental Health

Members: Marilyn Chase, Assistant Secretary of the Executive Office of Health and Human Services for Children, Youth and Families; Tom Dehner, Director of the Office of Medicaid; Angelo McClain, Commissioner of the Department of Social Services; Jane Tewksbury, Commissioner of the Department of Youth Services; and Sally Fogerty, designee of John Auerbach, Commissioner of the Department of Public Health.

Interagency Implementation Team

Members: Senior staff from the Departments of Mental Health, Mental Retardation, Public Health, Social Services and Youth Services, staff from the MassHealth Behavioral Health Unit and the Office of the Compliance Coordinator

Focus: Oversight and coordination of activities to:

- inform EOHHS child-serving state agency staff about the remedy and remedy services, including how to access services for children enrolled in MassHealth
- develop proposed policies and procedures to ensure participation by representatives of involved state agencies on care planning teams for children enrolled in Intensive Care Coordination
- develop proposed protocols to ensure coordination between any agency-specific planning process or the content of an agency-specific treatment plan through the care planning team process for children enrolled in Intensive Care Coordination
- develop a proposed conflict resolution process for resolving disagreements among care planning team members

MassHealth Implementation Team

Members: Representatives of all involved business units within MassHealth, senior staff from the Departments of Mental Health, Social Services and Youth Services and staff from the Office of the Compliance Coordinator

Focus: Oversight and coordination of all MassHealth implementation activities

Managed Care Entity (MCE) Workgroup

Sharon Hanson, MPH, Director, MassHealth Managed Care Program

Members: MassHealth Staff, Compliance Coordinator's Assistant Director, and the Behavioral Health Directors from each of MassHealth's MCOs and MBHP

Focus: Implementation of the remedy

Implementation Staff

In November, 2007, Suzanne Fields, LICSW, became the new Director of the MassHealth Behavioral Health Unit. Suzanne was previously the Director of Child and

Adolescent Services for MBHP. In this position she managed the implementation of the Coordinated Family-Focused Care (CFFC) program in five cities in Massachusetts. She developed and implemented an effective and highly collaborative method of managing these innovative Wraparound service planning and delivery programs.

The Compliance Coordinator has hired three staff:

Jack Simons, Ph.D., Assistant Director of Children's Behavioral Health Interagency Initiatives

Jack Simons was the Clinical Director of the CFFC program in Lawrence, MA, a distinguished program notable for innovative strategies to deliver culturally and linguistically competent services to children and families in Lawrence.

Margot Tracy, MS, Policy Analyst

Margot Tracy has experience in quality measurement and improvement, "best practice" afterschool programs and research regarding effective peer education models.

Michael Richards, Communications and Outreach Manager.

Michael Richards has extensive experience developing communication materials and strategies for MassHealth members, having been responsible for MassHealth's highly effective outreach to prospective members in 1997 when MassHealth significantly expanded its eligibility standards through its 1115 waiver. He also has experience handling media relations for the Department of Social Services.

### **Expert and Stakeholder Consultation Processes**

The CBHI Executive Committee has established a Children's Behavioral Health Advisory Council, which met for the first time on March 3, 2008. The Council is chaired by Barbara Leadholm, Commissioner of the Department of Mental Health, and consists of 29 members representing a broad range of stakeholders including families, youth with mental health needs, mental health providers and guilds. Senior staff from EOHHS child-serving agencies, the Director of Special Education for the Department of Elementary and Secondary Education, and representatives from the MCOs and MBHP attend Advisory Council Meetings as observers.

The purpose of the Advisory Council is to advise the Governor, the General Court, the Secretary of Health and Human Services and EOHHS agencies on matters concerning children's behavioral health.

### **Request for Information**

At the direction of the CBHI Executive Committee, the Office of the Compliance Coordinator prepared a "Request for Information" or "RFI." RFIs are used to solicit information and recommendations from policy stakeholders and potential providers of new or re-designed services. The RFI described the Defendants' system design work to date: preliminary plans for the service areas, the Community Service Agencies, the

clinical model for Intensive Care Coordination, and descriptions of the other services and how they will be delivered as part of a coherent system of services. The RFI solicited input by asking questions about particular aspects of the design and specifications.

In total, nearly 80 responses were received. The RFI responses inform design and specification decisions, which will be implemented through amendments to MassHealth's regulations and contracts with MBHP and the MCOs.

### **Other Expert and Stakeholder Consultation Processes**

The Defendants have been meeting with national consultants on children's behavioral health systems design provided by the Court Monitor.

The Defendants also convene or participate in ad hoc meetings with stakeholders on particular topics.

### **Delivery System Design and Implementation**

Subject to CMS approval, discussed more completely in Section c.iv, below, MassHealth is taking the following the following steps to implement delivery of services described in the Order:

#### **Selection of Community Service Agencies: Delivery of Intensive Care Coordination**

The Community Services Agencies (CSA) regions will be the same as the 29 areas of the Department of Social Services.

The CSAs will be selected by the Massachusetts Behavioral Health Partnership (MBHP), using criteria developed by the Defendants. The MCOs will be required to contract with the selected network of CSAs. The current plan is for MBHP to issue the Request for Responses to solicit prospective CSAs in mid-June, 2008.

Once the contracts have been executed, MBHP, the MCOs, and the selected CSAs will undertake organizational and staff development activities. The Defendants are attempting to implement ICC in advance of the court ordered compliance date of June 30, 2009. The current target date for implementation, subject to CMS approval and other network development activities, is April 1, 2009.

#### **Selection of Mobile Crisis Intervention Providers**

MassHealth has decided to utilize Emergency Services Providers to provide mobile crisis intervention services. MBHP has been directed to re-procure the network of ESP providers and incorporate the requirements of the Judgment for Mobile Crisis Intervention services for children and youth ages from birth to age 21. ESPs will be selected by MBHP, using provider qualifications established by DMH and MassHealth. The MCOs will be required to contract with the selected network of ESPs. The current

plan is for MBHP to issue the Request for Responses to solicit prospective ESPs in the Fall of 2008, with the goal of completing the selection and contracting processes by January 1, 2009. Providers will conduct organizational and staff development activities during the first six months of 2009, delivering emergency and mobile crisis services as of June 30, 2009, provided that CMS has approved the Defendant's State Plan Amendment.

#### Network Development for All Other Remedy Services

MBHP and the MCOs will be required to include providers of Crisis Stabilization, In-Home Behavioral Services, In-Home Therapy Services, and Mentor Services (both Therapeutic Mentoring and Parent/Caregiver Peer-to-Peer Support) in their Provider Networks provided CMS has approved the Defendant's State Plan Amendment. The defendants are working with MBHP and the MCOs to attempt to implement In-Home Therapy Services in advance of the court ordered compliance date of June 30, 2009 (again, subject to CMS approval and the Defendants' ability to complete network development activities).

#### Service Definitions and Specifications for All Remedy Services

The first step in the process of selecting providers for all remedy services, is MassHealth's creation of service definitions and specifications. These specifications, once finalized, become amendments to MassHealth's contracts with the MCOs and MBHP. MassHealth's Fee For Service regulations will also be amended as necessary and appropriate. The MassHealth Implementation Team will complete its work on the specifications in an order timed to the various procurement and selection processes. The initial draft of specifications for Intensive Care Coordination, the service to be delivered by the CSAs, are being extensively reviewed by the Monitor, her team of consultants and the Plaintiffs' attorneys.

Draft definitions and specifications have been prepared for all of remedy services and are in various stages of being reviewed and refined. The process of specification development and review with the Monitor, her consultants and Plaintiffs' attorneys is likely to continue into the early Fall.

#### Designing Utilization Management, Quality Management, Network Development and Network Management Approaches

MassHealth will work with the MCOs and MBHP throughout the Summer of 2008 to develop coordinated approaches to developing their networks of behavioral health providers, including providers of the remedy services, as well as coordinated approaches to utilization management, quality management and network management.

***c. Tasks performed will include:***

- i) Designing delivery system approaches that maximize access to services, taking into consideration the availability and willingness of providers to provide the services.*

As described above, the delivery system design process incorporates input from current service providers through a number of channels. The design has been developed paying careful attention to the issues of access and availability of providers. Responses received through the RFI validated the basic design approach. Workforce availability remains a great concern for providers, advocates and purchasers, including MassHealth. See the response to Paragraph 38.c.iii below.

- ii) Engaging in a public process to involve stakeholders in the development of the network and services.*

See response to Paragraph 38.b above.

- iii) Planning concerning anticipated need and provider availability.*

Given that staffing the current behavioral health system is an ongoing challenge for behavioral health provider agencies, the Defendants know that workforce availability is key to successful implementation of the remedy services. There are a number of initiatives underway and in the planning stages to address this issue, including:

- On March 28, 2008, the Defendants convened a second briefing for representatives from schools of social work, professional psychology, and nursing who could not attend the November 28, 2007 briefing. An extremely well-attended working meeting was held on April 18, 2008 to discuss both short and long term strategies for training and education of the existing and future clinical workforce. A follow up meeting is planned for June 17<sup>th</sup>. The April meeting resulted in the formation of a smaller workgroup that will assist the Defendants in planning a one day clinical workforce conference designed to introduce students and faculty to Wraparound and the larger system changes in children's mental health in Massachusetts.
- The Defendants are in the process of executing an Interdepartmental Service Agreement with the Commonwealth Corporation (CC), a quasi-public entity that works closely with the Commonwealth's Executive Office of Labor and Workforce Development. Through this ISA, CC will facilitate the development of a curriculum designed to train paraprofessionals who will be qualified, as members of a team lead by a clinician, to deliver the remedy's in-home services (In-Home Behavioral Services and In-Home Therapy Services). CC will research and define competencies, consult with providers and explore partnerships with community colleges as a venue for delivering this training with the hopes that such a training would count toward Associate's and Bachelor's degree credits.
- The Defendants are exploring opportunities and potential methods for working with family organizations to educate parents of children with behavioral health needs about: the potential increase in employment opportunities for Family Partners through

the remedy's Family/Caregiver Peer-to-Peer Support service; the required competencies; and opportunities for training.

- The Defendants will also consult with non-academic training agencies.
- The Defendants included questions regarding workforce issues in the RFI and these responses have been summarized into briefs and shared with all three of the main CBHI workgroups.

***iv) Working with CMS to obtain approval of services to be offered and of managed care contracting documents.***

The Defendants submitted State Plan Amendments (SPAs) for review and approval by the Centers of Medicare and Medicaid Services (CMS) on March 24, 2008. Prior to submission, MassHealth requested a pre-submission meeting with Central Office and Regional Office CMS staff to brief them on this case, the Judgment and the proposed State Plan Amendments. MassHealth expects the next step in the process will be to respond to questions from CMS regarding the SPAs. CMS has ninety days from the date the SPAs were submitted to provide the Commonwealth with a formal written Request for Additional Information (RAI). RAIs often include questions about the nature of the services described in the SPA, requests for additional assurances about the manner and method the services will be arranged to ensure compliance with applicable Medicaid requirements, and requests for modifications to the SPAs themselves. The Defendants will have ninety days to respond in writing to any such RAI. It is likely that CMS or the Defendants will request telephonic or in-person meetings in addition to any RAI.

Senior staff responsible for the relationship between EOHHS' Office of Medicaid and CMS are supporting this process and the Court Monitor has provided consultation to the parties by contracting with experts in the field. The Defendants anticipate working with the Monitor, the consultants and the Plaintiffs, to respond to CMS' questions.

***v) Defining CSA Service Areas.***

See the response to Paragraph 38.b above.

***vi) Defining standards with respect to provider qualifications, service delivery standards, training requirements, documentation requirements, utilization management standards, and performance measures.***

See the response to Paragraph 38.b above.

***vii) For each service described in Section I.D. above, defining the following: clinical criteria (including admission criteria, exclusion criteria, continuing stay criteria, and discharge criteria); performance specifications (including service definition and philosophy, structural requirements, staffing requirements, service, community and collateral linkages, quality management, and process specifications); credentialing criteria (for licensed clinicians and***

*paraprofessionals); and utilization management standards (prospective and retrospective).*

See paragraph 38.b above

*viii) Drafting contract and procurement documents, including the production of a detailed data set of contractors and the creation of detailed performance standards for contractors and providers.*

See paragraph 38.b above.

*ix) Negotiating contracts, setting rates for new services, and arranging for appropriate federal claiming protocols.*

Work has begun with the Commonwealth's rate setting agency, the Division of Health Care Finance and Policy (DHCFP), to develop fee for service (FFS) rates for the remedy services. These rates will be paid to providers serving MassHealth members in our FFS program. These rates will be one of the resources used to develop MassHealth's capitation payment to its MCOs and MBHP. Preliminary development work on the MCO and MBHP capitation rates for the first year that remedy services will be provided is underway.

*x) Performing reviews of new service providers to assure readiness to perform contract requirements.*

This will be performed by MBHP and the MCOs pursuant to the contract amendments negotiated and executed in 2008.

*xi) Designing strategies to educate providers, MassHealth Members, and the general public about the new services offered.*

As described in paragraphs 2-7 above, the first phase of this work -- educating providers, members, and the general public about standardized behavioral health screening -- is now complete.

The Defendants will revise all relevant communication materials, and use all of the communication channels, referenced in these paragraphs as each phase of the remedy is implemented. Updated materials will be disseminated prior to implementation of the CANS assessments and prior to implementation of the remedy services, as described in paragraphs 2-7 above.

*xii) Designing a system of contract management for managed care contracts that includes performance standards or incentives, required reports, required quality improvement projects, and utilization management review, administrative services, and claims payment protocols.*

The design work is underway by the MassHealth Implementation Team. See the response to Paragraph 38.b above for additional detail.

***d. Timeline for implementation:***

- i) Defendants will submit to the Court a written report with regard to completion of Project 3 no later than November 30, 2007. Further status reports thereafter may be required.***
- ii) Full implementation of this project will be completed by June 30, 2009.***

The Defendants submitted a report dated November 30, 2007 that fulfilled the requirement in subpart i. The Defendants are taking the steps described in paragraphs 19-33 above to complete this project by June 30, 2009, as required by subpart ii.

**Paragraph 39: Project 4: Information Technology System Design and Development**

- a. Project Purpose: The design and development of a web-based application to facilitate identification and monitoring of behavioral health service delivery to children with serious emotional disturbance.***

This section is a purpose statement, and requires no response.

***b. Tasks performed will include:***

- i) Defining existing system capacities.***
- ii) Gathering requirements for new functionality, including assessing whether development should be in-house or outsourced.***
- iii) Obtaining legislative authorization and funding.***
- iv) Drafting contract and procurement documents, including detailed architectural standards, privacy standards, and performance standards.***
- v) Working with CMS to obtain necessary federal approvals of contracting documents.***
- vi) Issuing an RFR, reviewing responses, and selecting bidder(s).***
- vii) Negotiating contract(s).***
- viii) Confirming business requirements and technical specifications.***
- ix) Performing construction and testing based upon the Unified Process***

- x) *Provider training development and delivery. In person training and web based training will be available.*

The Defendants plan to address the information technology system design and development project by leveraging and building on existing information technology resources, including existing information technology systems within EOHHS. Where possible, the reporting on utilization of services will be done through claims and managed care encounter data. Other clinical systems will be based on existing EOHHS systems to the extent feasible.

Thus far, the Defendants have taken the following steps:

**Defining Existing System Capacities:**

During January through March 2007, the Defendants worked with an outside consultant to determine whether an enterprise-wide service management (ESM) system currently under development for EOHHS would meet the requirements of the Judgment. After consulting with program managers and IT professionals from MassHealth, EOHHS IT, DSS, DYS and DMH to gather high-level system requirements, it was determined that the ESM system would not have the required functional capacity. As a result, the Defendants decided to sequence the IT approach in two phases. The first phase will be to develop an IT solution that, subject to consent from the child or the child's parent, guardian, or custodian, can collect CANS data from MassHealth behavioral health providers and share it with the child's MCO or MBHP, if applicable (CANS IT Application). The second phase will be to develop a solution that can collect data from the CSAs regarding ICC and the delivery of the new services for children with SED.

EOHHS IT next conducted an internal review of existing agency data systems to determine if any of these systems could be leveraged to meet the needs of the Judgment. It was determined that certain components of the DSS STARS system provide functionality that is similar to that which is required to administer the CANS tool. Therefore, the Defendants have decided to take this system as the starting point for developing the IT platform for the CANS tool.

**Gathering Requirements for New Functionality:**

In addition to developing high-level requirements, as described above, the Defendants hired 2 business analysts, and assigned an IT project manager to develop detailed requirements and use case documents for the IT approach. The business analysts are following an IT methodology for developing requirements, called the "unified process," which involves detailing how users would interact with an IT system in their day-to-day work, and documenting these processes in use cases. The development of use cases requires a detailed knowledge of both existing and new business process flows that will be occurring at EOHHS agencies, at any managed care entities under contract with MassHealth, and at the community provider level.

The business analysts have completed the vision document and requirements document. These two artifacts have been signed off on by the business users. The use case document is nearly complete.

It has been determined that the system will be developed in-house. The structure of the DSS Stars application has been leveraged to begin development of the system.

Two developers were hired and have completed a systems architecture document, which has been reviewed and approved by senior IT managers in EOHHS and MassHealth. By the end of May 2008 there will be a follow up architecture review to finalize the integration of outside systems that will be used for data exports, certification validation and security validations.

A complete database schema has been completed. Two new servers have been purchased and are being set up for continued development. One server will be used for development and the other for system testing. Once the application has been thoroughly tested it will be moved into production on an existing production server in the Virtual Gateway environment.

**Obtaining Authorization and Funding:**

Defendants have developed a budget for system implementation and obtained the necessary funding.

**System Development, Contracting and Procuring:**

EOHHS has initiated development of two web-based applications to support the use of the CANS. The first application is the CANS Certified Assessor Training and Certification Application developed and hosted through an interagency service agreement with the University of Massachusetts. This application is designed to perform several functions: (1) permit clinicians to register for face-to-face Certified Assessor Training; (2) provide web-based Certified Assessor Training for those that choose not to take the face-to-face training, and (3) administer the Certified Assessor Examination, and issue credentials to clinicians who pass the examination. The training registration function for face-to-face Certified Assessor Training, and the Certified Assessor Examination went live on May 12, 2008; the web-based Certified Assessor Training will go live this summer.

MassHealth Behavioral Health clinicians are currently using the Certified Assessor Application to register for face-to-face training and to take the Certified Assessor Examination after completion of that training.

The second application is the CANS IT Application, which is being developed by EOHHS and which will be hosted through the Virtual Gateway. The CANS IT Application will allow clinicians to enter client CANS and SED determination information into a secure EOHHS database, subject to necessary consents. The CANS IT Application will provide data needed for court reporting, and for other clinical and administrative purposes.

Existing internal architecture will be utilized for security and production testing and development processes.

The Virtual Gateway provides a secure, reliable platform that is accessible to people with disabilities. VG personnel are experienced in working with provider agencies to provide user access and support. Staff from the Virtual Gateway participate in weekly meetings with CBHI staff regarding implementation of the CANS tool via the Virtual Gateway, reviewing a variety of issues including security and privacy, enrollment of provider agencies with the VG, end user training and support, and effective coordination of services between the CANS Assessor Training Application (hosted by the University of Massachusetts) and the CANS Application hosted on the VG.

Provider organizations are currently being contacted by personnel from VG, who assist the provider organizations in understanding VG enrollment procedures, including designation of provider staff to appropriate security roles. Once this enrollment and designation procedure is complete, provider staff members who have appropriate security roles will be able to use the CANS IT Application when it goes live. Desk support will be available for the CANS IT Application through the VG.

***c. Timelines for implementation***

- i) Defendants will submit to the Court a written status report with regard to Project 4 no later than November 30, 2007.-Complete***
- ii) Full completion of this project will be by November 30, 2008.***

The Defendants submitted a report dated November 30, 2007 that fulfilled the requirement in subpart i. The Defendants are taking the steps described in paragraphs 39-46 to complete this project by November 30, 2008, as required by subpart ii.

***Paragraph 40: There are multiple sources of data available to the Medicaid agency and multiple methods for data collection. This Judgment outlines a basic data set that, based on sound principles of program management, will ultimately provide very useful data that will support the agency's ability to track, monitor and evaluate a system of behavioral health care for children with SED. Some of the data points outlined here are presently available or easily accessible, while others are not.***

This paragraph is introductory; see response to paragraph 39 above.

***Paragraph 41: The primary source for Medicaid data is MassHealth's claims payment system, known as the Medicaid Management Information System (MMIS). While MMIS can collect claims level data on utilization and spending, it is not a good source for much of the data required to evaluate the implementation beyond that otherwise necessary for providers to claim reimbursement from MassHealth. EOHHS is currently part way through a major multi-year project to develop a replacement MMIS (New MMIS), currently anticipated for implementation in August, 2007.***

This paragraph is introductory; see response to paragraph 39 above.

**Paragraph 42:** *A secondary means of collecting data commonly used in MassHealth program management originates from contract requirements, typically of managed care entities. MassHealth often requires managed care entities to collect data or report information in a particular form as an obligation of the contract. This method of collecting data is not limited by the capacities of the MassHealth payment system, but may be hampered by the managed care entities' own system limitations. Any business requirements placed on contractors generally require time to make business process changes and systems modifications as well as some form of reimbursement of costs.*

This paragraph is introductory; see response to paragraph 39 above.

**Paragraph 43:** *For detailed clinical and provider performance data, MassHealth's clinical staff and contracted reviewers undertake clinical record reviews. This method of collecting data is appropriate in very limited circumstances and is time-intensive and costly.*

This paragraph is introductory; see response to paragraph 39 above.

**Paragraph 44:** *For collecting and managing all of the data points associated with this Judgment, EOHHS will need to develop a new information technology (IT) application. Although the Defendants are not required by the Medicaid Act (42 U.S.C. §1396 et seq.) to collect this data, EOHHS believes that the data will assist in assessing its performance of the requirements of the Judgment, to improve the quality of Medicaid behavioral health services for children, and to reassure the Court of success. However, an IT systems development project is a significant undertaking. The Defendants will need specific legislative authorization and appropriation in order to proceed with an IT project of the size contemplated below, since it would involve a capital appropriation and expenditure authorization. Following that, the Defendants can engage one or more vendors through a competitive procurement process; design business specifications with input from the MassHealth provider community; allow time for the vendor to build and test the data collections and management system(s); amend provider agreements and contracts, as necessary; and train providers to report required information using the new IT application. Timetables for such large-scale IT projects usually range from 18-24 months from the time that legislative authorization and appropriation is received, and often include multiple rollouts of advancing sophistication and breadth to assure that providers can successfully use the application and that the data collected is accurate and timely.*

Provider organizations are being contacted now to set up their Virtual Gateway accounts and to set security roles that will provide access to appropriate end users. A support structure is being developed to support the providers during this crucial setup phase.

**Paragraph 45:** *With these considerations in mind, the Judgment includes the following as a preliminary data collection strategy to assess Member access to, and utilization of, 25 EPSDT behavioral health screenings, clinical intake assessments, intensive care coordination, comprehensive assessments, and intensive home based services. Data points described below that are not available from MMIS are conceptual and subject to a complete inventory of the*

***business requirements and data elements necessary for creating an appropriate tracking system or systems.***

Wherever possible, the Defendants plan to use claims data from MMIS and encounter data from the MCOs and MBHP. Encounter data is client- and service-specific data reported by the MCOs and MBHP to MassHealth. Claims data is data from the claims that providers who service MassHealth members on a fee for service basis submit to MassHealth for reimbursement.

As explained in more detail in response to paragraph 46 below, there are some measures which will require the collection of new data or the combination of new data with existing claims and encounter data.

**Paragraph 46: Potential Tracking Measures**

***a. EPSDT Behavioral Health Screening***

- i) Number of EPSDT visits or well-child visits and other primary care visits.***
- ii) Number of EPSDT behavioral health screens provided. An EPSDT behavioral health screen is defined as a behavioral health screen delivered by a qualified MassHealth primary care provider.***
- iii) Number of positive EPSDT behavioral health screens. A positive screen is defined as one in which the provider administering the screen, in his or her professional judgment, identifies a child with a potential behavioral health services need.***

The Defendants will use MMIS claims data and encounter data to report on all three of these measures. There is a lag in time between service provision and claims payment, and also in the submission of MCO data to EOHHS; therefore, it is expected that the Defendants will have data to test the reporting function in May 2008, and will have a full data set to report to the Court by November 30, 2008.

More detailed information about each of the three measures follows.

The ability to report on EPSDT or well child visits and other primary care visits already exists and is part of MassHealth's quality improvement measures. The existing report is from MMIS only, so a new programming specification has been developed to incorporate MCO encounter data.

The Defendants will report on the number of EPSDT behavioral health screens provided by implementing a specific code that all primary care providers, including those in an MCO network, will use when billing for behavioral health screens. The MassHealth and MCO system requirements necessary to report this code have been made. The Defendants have developed the programming for the report from our MMIS and MCO encounter data.

The Defendants will report on the number of screens identifying a child with a potential behavioral health services need through the use of specific “modifiers” that all primary care providers, including those in an MCO network, will use when billing the code for the behavioral health screen. These modifiers will indicate both the type of provider that performed the screen, as well as whether the screening was positive or not. The MassHealth and MCO system requirements necessary to report this code have been made. The Defendants have developed the programming for the report from our MMIS and MCO encounter data.

***b. Clinical Assessment***

- i) Number of MassHealth clinical assessments performed. A MassHealth clinical assessment is defined as any diagnostic, evaluative process performed by a qualified MassHealth behavioral health provider that collects information on the mental health condition of an EPSDT-eligible MassHealth Member for the purposes of determining a behavioral health diagnosis and the need for treatment.***
- ii) Number of clinical assessments that meet SED clinical criteria and indicate that the Member could benefit from intensive care coordination services.***

The Defendants plan to approach reporting on clinical assessments in two ways.

The Defendants will first report on the number of assessments through MMIS and encounter data. Through work with the Division of Health Care Financing and Policy (DHCFP), the MCOs, and MBHP, the Defendants identified a coding strategy for billing and reporting on clinical assessments. The Defendants plan to have the system in place to report this data from claims by November 30, 2008. Because the deadline for implementing the clinical assessments is also November 30, 2008, the first reports from claims with any substantial amount of data will be produced later.

In addition to reporting based on claims, the Defendants plan to report on these measures through the online CANS IT Application described in paragraph 39.b. This will allow behavioral health providers to enter CANS data online. The capability to report on the number of assessments performed, and on the number of assessments where the child met SED criteria, are built into the CANS IT Application.

***c. Intensive Care Coordination Services and Intensive Home-Based Assessment***

- i) Number of intensive home-based assessments performed as the first step in intensive care coordination. Such assessment processes shall result in the completion of a standardized data collection instrument (i.e. the CANS tool). As part of the treatment planning process, that standardized tool will be used, and the resulting data collected on a Member level at regular intervals.***
- ii) Number of Members who receive ongoing intensive care coordination services.***

The Defendants will report on ICC services delivered to new members in a given time period, as well as the total number of members who are receiving ongoing ICC services. The Defendants plan to report on both of these measures using claims and encounter data by using specific codes and modifiers which have been identified by DHCFP.

Additionally, the Defendants plan to use the data collected using the online CANS IT Application described in paragraph 46.b above to report on the number of assessments completed by the ICC team. The Defendants currently are developing these requirements.

The Defendants plan to have the coding, MMIS, and data warehouse changes as well as the on-line CANS IT Application complete by November 30, 2008. However, since ICC will not be fully implemented until June 30, 2009, there will be limited data from claims to report on these indicators until after the services have been implemented.

***d. Intensive Home-Based Services Treatment***

- i) Member-level utilization of services as prescribed under an individualized care plan, including the type, duration, frequency, and intensity of home-based services.***
- ii) Provider- and system-level utilization and cost trends of intensive home-based services.***

The Defendants are considering reporting on the member-level utilization of services as prescribed under an individualized care plan by linking an electronic treatment planning record to actual services provided (as reported in claims). Many of the large providers have their own electronic treatment records, as do managed care companies for members in care management programs. The Defendants currently are gathering requirements for linking care plans to the services provided, and looking at the needs of the providers and their treatment planning systems, the existing treatment plans that link to claims payment in managed care systems, and in-house, on-line treatment plan systems currently used by providers contracted with DSS. Currently it appears that managed care organizations have the most complete infrastructure for recording data on care plans and being able to link those plans with actual services provided.

The Defendants anticipate that the approach developed to meet this requirement will be ready for use by the time ICC and in-home services are implemented in June 2009.

Since members will begin utilizing services only after their initial care plans are developed, it is likely that the first reports to contain a significant amount of actual data on utilization of services as prescribed, will be ready approximately six months after services are substantially implemented.

- e. Child and Outcome Measures - Member-level outcome measures will be established to track the behavioral health of an EPSDT-eligible MassHealth Member with SED who has been identified as needing intensive care coordination services over time. Defendants will consult with providers and the academic literature and develop***

***methods and strategies for evaluating Member-level outcomes as well as overall outcomes. Member-level outcome measures would be tracked solely for the purpose of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.***

The Defendants currently are researching potential member-level outcome measures. The Defendants will consult with the Children's Behavioral Health Advisory Council, the Monitor and the Plaintiffs as they identify these measures.

In addition, the Defendants are researching appropriate tools to measure the fidelity of clinical practice to the wraparound model. Measuring outcomes without measuring the service delivered limits the ability to evaluate the program.

Because ICC is a long-term, rather than an acute care service, meaningful outcome measurement will require members to receive ICC for at least six months before there is any initial data on outcomes. Therefore, while the Defendants anticipate having a system in place to collect outcome data at the time that the new services for children with SED are implemented in June 2009, the first reports on outcomes will not be available for at least six months afterwards.

***f. Member Satisfaction Measures - Defendants will develop sampling methods and tools to measure Member satisfaction of services covered under this Judgment. Member satisfaction would be measured solely for the purpose of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.***

The Defendants plan to conduct member satisfaction surveys based on a random sample of members who have had some experience with the services covered under the Judgment. The Defendants intend to contract with a vendor to develop these surveys.

RESPECTFULLY SUBMITTED

---

Dated: May 30, 2008